

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 27-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

## 1. PLACE OF DEATH:

County Somerset  
 City or town Crisfield  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 months & 1 da.  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Somerset  
 City or town Crisfield  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 31 Chesapeake Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Stephen Randall Barnes Jr.

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced \_\_\_\_\_  
 6.(b) Name of husband or wife \_\_\_\_\_ 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) April 13, 1945  
 8. AGE: Years \_\_\_\_\_ Months 5 Days 1 \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Crisfield-Somerset-Maryland  
 (Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER 12. Name Stephen Barnes  
 13. Birthplace Hopkins, Virginia  
 14. Maiden name Doris E. Kellam  
 15. Birthplace Onancock, Virginia

16. Informant Stephen Barnes  
 Address 31 Chesapeake Ave. Crisfield,

17. Burial Date thereof Sept. 16, 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Holly Cemetery  
 Location Onancock, Virginia

18. Funeral director H. Harvey Bradshaw  
 Address Crisfield, Maryland

19. 9/15/46 19 66  
 (Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 19 45, at 9 A: M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 11 19 45, to Sept 14 19 45, and that I last saw him alive on Sept 14, 1945 19 \_\_\_\_\_

Immediate cause of death Secondary Dysentery DURATION 4 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically. Id.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE S. M. Payton M.D. M. D. or otherAddress Crisfield, Md. Date signed Sept 14, 1946

RECEIVED  
SEP 27 1945  
BUREAU V.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23d)

## CERTIFICATE OF DEATH

09266

★ Reg. Dist. No. 260

## 1. PLACE OF DEATH:

County Somerset  
City or town Upper Fairmount  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? all lifeHospital, institution, or street address where death occurred:  
Sept 28, 1945 A.M.

How long in hospital or institution?

## 3. (a) FULL NAME

Charles C. Bennett

## 3. (b) Social Security Number

4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Nina B. Bennett

8. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 4 - 18778. AGE: Years 68 Months . Days . If less than one day68 hrs. min.9. Birthplace Somerset Co. Md.  
(Town, county, and state)10. Usual occupation Waterman

11. Industry or business

12. Name Mr. Bennett13. Birthplace Maine14. Maiden name Sarah Revell15. Birthplace Md.16. Informant Nina BennettAddress Upper Fairmount17. Burial Date thereof Sept 30, 1945  
(Burial, cremation, or removal, Which?) (Month) (day) (year)Cemetery or crematory Family Burial GroundLocation Upper Fairmount18. Funeral director Harry B. MilesAddress Upper Fairmount, Md.Sept. 28, 1945  
(Date rec'd by registrar)R. J. Johnson M.D.  
Registrar

Sec. g.d.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Fairmount  
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2. (a) If veteran, name war .....

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 19 45 at 6: A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., 10....., 19.....

and that I last saw him..... alive on ..... 19.....

Immediate cause of death Chronic Myocarditis

DURATION

Due to.....

Due to.....

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE G. Smith

M. D. or other

Address Upper Fairmount, Md.Date signed 9/28-45

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

MEDICAL CERTIFICATION

RECEIVED  
OCT 1 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of year of birth is shown on

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 265

## 1. PLACE OF DEATH:

County... Somerset

City or town... Crisfield  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Somerset

City or town... Crisfield  
(If outside city or town limits, write RURAL and give nearest town)

Street No... Hardy Ave  
(If rural, give LOCATION)

2(a) If veteran, name war... WW

## 3. (a) FULL NAME

Milton Bathin

## 3. (b) Social Security Number

213-09-4841

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Eva

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1890 1889

8. AGE: Years 55 Months 9 Days 5 It less than one day

9. Birthplace Somerset Co. Md.  
(Town, county, and state)

10. Usual occupation Sea Food

11. Industry or business L. B. Garrison Co.

12. Name John A. Bathin

13. Birthplace Somerset Co.

14. Maiden name Harriet E. Reelle

15. Birthplace Somerset Co., Md.

16. Informant Eva Bathin

Address Crisfield Md

17. Burial (Burial, cremation, or removal, which?) Burial Date thereof 9/15/45  
(month) (day) (year)

Cemetery or crematory Sunny Ridge

Location Crisfield

18. Funeral director Howard H. Hubbard

Address 306 Main St

19. 9/14/45 (Date rec'd by registrar)

E. E. Collins Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3 1945, at 6 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1944, to Sept 3 1945

and that I last saw him alive on Sept 3 1945

Immediate cause of death

Chronic

myocarditis

Due to Chronic myocarditis

Due to Chronic myocarditis

Other conditions Asthma & emphysema

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. M. Peyton M. D. or other

Address Crisfield Md Date signed Sept 4, 1945

RECEIVED  
SEP 27 1945  
BUREAU A.B.





RECEIVED  
SEP 27 1945  
BUREAU T.M.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 260

## 1. PLACE OF DEATH:

County SomersetCity or town Princess Anne  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Princess Anne  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Betty Jane Jones

## 3. (b) Social Security Number

4. Sex

female

5. Color or race

col.

6.(a) Single, married, widowed, or divorced

single

6.(b) Name of husband or wife .....

6.(c) If alive, give age ..... years

7. Birth date of

deceased (mo., day, yr.)

Sept. 14, 1945

8. AGE:

Years

Months

Days

If less than one day

3

hrs. .... min.

9. Birthplace

Princess Anne  
(Town, county, and state)

10. Usual occupation .....

11. Industry or business .....

FATHER  
MOTHER

12. Name

George Ward

13. Birthplace

Philadelphia, Pa.

14. Maiden name

B. Jones

15. Birthplace

Princess Anne

16. Informant

B. Jones Collins

Address

Princess Anne

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

(month) (day) (year)

Sept. 17, 1945

Cemetery or crematory

Mt. Hope Cemetery

Location

Greenwood - Pr. Anne, Md.

18. Funeral director

William James & Son

Address

Princess Anne, Md.

19.

(Date received by registrar)

19

45R. J. Johnson, M.D.  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17, 1945 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death

Heart failure from  
embolism

DURATION

Due to.....

Due to.....

Other conditions .....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Henry M. Loufford, M.D.  
M. D. or other

Address

Princess Anne, Md.

Date signed

9/17/45

RECEIVED  
SEP 22 1945  
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1027265

## 1. PLACE OF DEATH:

County..... **Somerset**  
 City or town..... **Crisfield**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... **28 years**  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... **Maryland** County..... **Somerset**  
 City or town..... **Crisfield**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... **Broadway**  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

**Robert Kelley**

## 3. (b) Social Security Number

4. Sex <b>Male</b>	5. Color or race <b>Colored</b>	6.(a) Single, married, widowed, or divorced <b>Single</b>
6.(b) Name of husband or wife.....		
6.(c) If alive, give age..... years		
7. Birth date of deceased (mo., day, yr.) <b>December 20, 1905</b>		
8. AGE: Years <b>39</b>	Months <b>8</b>	Days <b>24</b> hrs. min.
9. Birthplace..... <b>Kentucky</b> (Town, county, and state)		
10. Usual occupation..... <b>Waterman</b>		
11. Industry or business <b>Oyster boats</b>		
FATHER	12. Name..... <b>Unknown</b>	
	13. Birthplace..... <b>"</b>	
MOTHER	14. Maiden name..... <b>"</b>	
	15. Birthplace..... <b>"</b>	
16. Informant..... <b>Amanda Ward</b> Address..... <b>Broadway, Crisfield, Md.</b>		
17. Burial Date thereof..... <b>Sept. 17, 1945</b> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory..... <b>Lawsonia Cemetery</b> Location..... <b>Crisfield, Maryland</b> Funeral director..... <b>H. Harvey Bradshaw</b> Address..... <b>Crisfield, Maryland</b>		
19. <b>9/15/45</b> 19 <b>6. E. Collins, M.D.</b> (Date rec'd by registrar) Registrar		

## MEDICAL CERTIFICATION

20. DATE OF DEATH **Sept 14 1945** at **7:30 P.M.**  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Sept 14 1945** to **Sept 14 1945** and that I last saw him on **Sept 14 1945**  
 Immediate cause of death..... **Acute Cardiac Distention**  
 Due to..... **Pneumonia**  
 Other conditions..... **Tuberculosis**

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

SIGNATURE..... **H. E. Collins, M.D.**  
 Address..... **Crisfield, Md.** Date..... **Sept 15/45**

RECEIVED  
SEP 27 1945  
BUREAU A.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09271

Reg. Dist. No. 270

1. PLACE OF DEATH: Somerset  
County.....  
City or town..... Crisfield  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 7 days  
Hospital, institution, or street address where death occurred:  
McCreedy Memorial Hospital  
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Maryland County..... Somerset  
City or town..... Kingston  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

## 3. (a) FULL NAME

George Lane

## 3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) ? ? 1886 8. (c) If alive, give age..... years

8. AGE: Years 59 Months ? Days ? It less than one day hrs. min.

9. Birthplace Kingston-Somerset-Maryland  
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Truck farms

12. Name James Lane

13. Birthplace Marumsco, Maryland

14. Maiden name Ellen Jones

15. Birthplace Marumsco, Maryland

16. Informant Mrs Manie Waters

Address Broadway, Crisfield, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 12, 1945  
(month) (day) (year)

Cemetery or crematory Centennial Cemetery

Location Fairmount, Maryland

18. Funeral director H. Harvey Bradshaw

Address Crisfield, Maryland

19. 9/11/45 (Date rec'd by registrar) 20. C. E. Collins M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 9, 1945, at 8:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dead when I was  
and that I last saw him alive on 1945

Immediate cause of death Colloid

Fractured skull

Due to Stroke =

I was hit by auto on

State road while

riding bicycle with light.

(Include cause of death in months of death in month, M. D.)

Major findings of operation DEPUTY MEDICAL EXAMINER

FOR SOMERSET COUNTY, MD.

Autopsy results. No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date Sept 2-45

Where did injury occur Crisfield Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) State Road

Means of injury riding bicycle without light

H. H. Coulbourn MD

23. SIGNATURE Crisfield Md

Address Crisfield Md Date Sept 11-1945

BUREAU A.B.  
SEP 27 1965  
KROON & EID



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(131-2)

## CERTIFICATE OF DEATH

Reg. Dist. No. 19272-270

## 1. PLACE OF DEATH:

County Somerset  
City or town Crisfield  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, institution, or street address where death occurred:

McCreedy Memorial HospitalHow long in hospital or institution? 11 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town RURAL, Marion  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2 (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

John L. Matthews

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Carrie Williams Matthews6. (c) If alive, give age 62 years7. Birth date of deceased (mo., day, yr.) October 17, 18808. AGE: Years Months Days If less than one day  
64 11 18 hrs. min.9. Birthplace Somerset County, Maryland  
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

12. Name John L. Matthews  
13. Birthplace Somerset County, Maryland14. Maiden name Rosetta Dennis  
15. Birthplace West Post Office, Maryland16. Informant Clarence Matthews  
Address Marion, Maryland17. Burial Date thereof October 3, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Pauls CemeteryLocation Marion, Maryland18. Funeral director H. Harvey BradshawAddress Crisfield, Maryland19. 10/3 45 Paula B. Sawyer Registrar  
(Date rec'd by registrar) (Date) (Month) (Year) Address C. E. Collins, Jr.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30, 1945 at 8:30 A.M.I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15, 1945 to Sept 30, 1945  
and that I last saw him alive on Sept 29, 1945Immediate cause of death Acute die of heart DURATION 2 weeksDue to Cirrhosis of the liverDue to Chronic active hepatitis not h.Other conditions Chronic heart disease

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Paula B. Sawyer M. D. or otherAddress St. Pauls Cemetery Date signed Oct 2, 1945

CERTIFICATE OF DEATH

RECEIVED  
OCT 27 1945  
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

## CERTIFICATE OF DEATH

09273

Reg. Dist. No. 260

## 1. PLACE OF DEATH:

County SomersetCity or town Princess Anne  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 yearHospital, institution, or street address where death occurred:  
P.O. #1.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County SomersetCity or town Princess Anne  
(If outside city or town limits, write RURAL and give nearest town)Street No. P.O. #1.  
(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3.(a) FULL NAME

Addie Frances McBee

## 3.(b) Social Security Number

## 4. Sex

female

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Widow

## 6.(b) Name of husband or wife

Charles Henry McBee6.(c) If alive, give age. Deceased years

## 7. Birth date of deceased (mo., day, yr.)

Jan. 14 - 1862

## 8. AGE:

Years 83 Months 7 Days 17 If less than one day  
hrs. min.

## 9. Birthplace

Pocomoke Md.  
(Town, county, and state)

## 10. Usual occupation

Home life

## 11. Industry or business

at Home

## FATHER

## 12. Name

John Rose

## 13. Birthplace

Somerset Co. Md.

## MOTHER

## 14. Maiden name

Emily King

## 15. Birthplace

England

## 16. Informant

Mrs. Mabel Chaffey

## Address

P.O. #1. Princess Anne Md.

## 17. Burial

Buried

## (Burial, cremation, or removal. Which?)

Date thereof Sept. 3, 1945  
(month) (day) (year)

## Cemetery or crematory

Sandy Hill Cem.

## Location

New Bethel town Del.

## 18. Funeral director

Shellman & Co. Walter R. Hilling

## Address

Salisbury Maryland

## Date

Sept. 2, 1945

## (Date rec'd by registrar)

## Registrar

N. B. Johnsonfor

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1st 1945 at 10:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 15 1945 to Sept 1 1945and that I last saw him/her alive on Sept. 1945

## Immediate cause of death

Cerebral arteriosclerosis

## Due to

fractured arteries & veins

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

## SIGNATURE

Frank Heaters M. D. or otherAddress Princess Anne Date signed Sept. 2, 1945

RECEIVED  
SEP 5 1945  
BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

## CERTIFICATE OF DEATH

Reg. Dist. No. 260

### 1. PLACE OF DEATH:

County Somerset  
City or town Princess Anne md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State md County Somerset

City or town Princess Anne md  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

George Hammond Myers

### 3. (b) Social Security Number

None

4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Imogene F. Myers

6. (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Nov 8, 1877

8. AGE: Years 66 Months 10 Days 11 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Fredrick Co. md.  
(Town, county, and state)

10. Usual occupation Lawyer

11. Industry or business \_\_\_\_\_

12. Name Samuel G. Myers

13. Birthplace New Oxford, Pa.

14. Maiden name Fannie Hammond

15. Birthplace Fredrick Co. md.

16. Informant Hammond Myers

Address 174-36 St. N.E. Washington D.C.

17. Burial Date thereof Sept 22, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Manakin Cemetery

Location Princess Anne, md

18. Funeral director Wale Dashiell

Address Princess Anne, md

19. Sept 23, 1945 R. J. Schaefer  
(Date rec'd by registrar) (month) (day) (year) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Sept-20th 1945 at 10: P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death Cerebral Hemorrhage DURATION 12 hrs.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Dist-1st

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. Schaefer

Address Princess Anne md

Date signed 9/21-45

\_\_\_\_\_ M. D. or other

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
SEP 26 1903  
BUREAU A.M.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

## CERTIFICATE OF DEATH

Reg. Dist. No. 09275 350

## 1. PLACE OF DEATH:

County SomersetCity or town RURAL, Pocomoke City  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Georgia County BurkeCity or town RURAL, Waynesboro  
(If outside city or town limits, write RURAL and give nearest town)Street No. # RED 1  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Joe Slydell

## 3. (b) Social Security Number

NO

## 4. Sex

Male

## 5. Color or race

Colored

## 6. (a) Single, married, widowed, or divorced

Married

## 8. (b) Name of husband or wife

6. (c) If alive, give age ..... years

## 7. Birth date of

deceased (mo., day, yr.)

January 17, 1910

## 8. AGE:

Years

Months

Days

If less than one day

35722

hrs.

min.

## 9. Birthplace

Waynesboro-Burke-Georgia

(Town, county, and state)

## 10. Usual occupation

Farm laborer

## 11. Industry or business

Cottor farms

FATHER

## 12. Name

William Slydell

## 13. Birthplace

Waynesboro, Georgia

MOTHER

## 14. Maiden name

Mosiak Turner

## 15. Birthplace

Waynesboro, Georgia

## 16. Informant

Sidney Slydell

## Address

Marlboro, New Jersey

## 17.

Removal  
(Burial, cremation, or removal. Which?)Date thereof Sept. 10, 1945  
(month) (day) (year)

## Cemetery or crematory

Rock Creek Cemetery

## Location

Waynesboro, Georgia

## 18. Funeral director

H. Harvey Bradshaw

## Address

Pocomoke City, Maryland

## 19.

Sept 10 19 45  
(Date rec'd by registrar)Anne E. [Signature]  
Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Sept 9 19 45 at 2:30 P

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., 10....., 19.....

and that I last saw him

alive on

19.....

## Immediate cause of death

Lymphatic Leukemia

## DURATION

## Due to

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. ....

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of .....Where did injury occur? .....  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Not injured

Means of injury ..... Injured at work?

## 23. SIGNATURE

[Signature]  
M. D. or other  
Date signed 9/10/45

RECEIVED  
SEP 12 1945  
BUREAU T.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09276

Reg. Diat. No. 265

## 1. PLACE OF DEATH:

County SomersetCity or town Crusfield  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 37 yrs

Hospital, institution, or street address where death occurred

How long in hospital or institution? 9 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County SomersetCity or town Crusfield  
(If outside city or town limits, write RURAL and give nearest town)Street No. 319 Locust St  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Lilla Elizabeth Frances Thomas

## 3. (b) Social Security Number

217-09-5306

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Alonso Thomas

7. Birth date of

deceased (mo., day, yr.)

July 9-19086. (c) If alive, give age 34 years

8. AGE:

Years

Months

Days

If less than one day

37217

hrs.

min.

9. Birthplace Marion Somerset Co MD  
(Town, county, and state)10. Usual occupation Seafood work

11. Industry or business

FATHER

12. Name

Charles Nottingham

13. Birthplace

Marion Somerset Co MD

MOTHER

14. Maiden name

Bertie Hoisey

15. Birthplace

Hopewell Somerset Co MD

16. Informant

Chas S. Miles

Address

Marion MD17. burial

(Burial, cremation, or removal. Which?)

Date thereof Sept 30-1945  
(month) (day) (year)

Cemetery or crematory

Wesley

Location

Marion MD

18. Funeral director

Chas H Ward

Address

Marion MD19. 9/29/45

(Date rec'd by registrar)

19

C. E. Collins, M.D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1945, at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1 1945, to Sept 26 1945and that I last saw him alive on Sept 26 1945Immediate cause of death urinaryacute de vent

DURATION

4 days

Due to

Due to failure of heartOther conditions hypertension

(Include pregnancy within 3 months of death)

Major findings of operations As aboveDate of op. Sept 20 45Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?23. SIGNATURE Wm O. Collins MD

M. D. or other

Address Marion MDDate signed 9/29/45

RECEIVED  
OCT 2 1945  
BUREAU V.G.

040191

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19-6

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

## 1. PLACE OF DEATH:

County Somerset  
 City or town Crisfield  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 yrs  
 Hospital, institution, or street address where death occurred:  
Main St  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Somerset  
 City or town Crisfield  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Rose apt - Main St  
 (If rural, give LOCATION)  
 2(a) If veteran, name war

## 3. (a) FULL NAME

Catherine S. Lerner

## 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife George J. Lerner  
Married 1960 6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Oct. 18, 1867

8. AGE: Years 77 Months 11 Days 21 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Accomac County, Va  
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Thomas Lerner Handley

13. Birthplace Accomac County

MOTHER 14. Maiden name Emily Kilgus

15. Birthplace Accomac County

16. Informant Mrs. Elliott Richardson

Address Crisfield, Md

17. Removal Date thereof Sept 28/45  
 (Burial, cremation, or removal. When?) (Month) (day) (year)

Cemetery or crematory Mt Holly Cemetery

Location Orange Cove Va.

19. Funeral director Burke & Johnson

Address Orange Cove Va

19. 9/28/45 Registrar Co E. Coleman  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 28 1945, at 10:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 24 1945 to Sept 28 1945

and that I last saw her alive on Sept. 27 1945

Immediate cause of death Pulmonary Tuberculosis DURATION 26 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE L. M. Peyton M.D. M. D. or other

Address Crisfield, Md Date signed Sept. 28

CERTIFICATE OF DEATH

UNITED STATES DEPARTMENT OF JUSTICE

UNITED STATES DEPARTMENT OF JUSTICE

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED  
OCT 12 1945  
BUREAU V S.

UNITED STATES DEPARTMENT OF JUSTICE



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

19278

## CERTIFICATE OF DEATH

Reg. Dist. No.

261

## 1. PLACE OF DEATH:

County.....

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

Sarah J. Whittington

4. Sex.....

Female

5. Color or race.....

Colored

6. (a) Single, married, widowed, or divorced.....

Married

6. (b) Name of husband or wife.....

A. H. Whittington

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....

Sept 3 1878

8. AGE: Years..... Months..... Days..... If less than one day..... hrs..... min.

67 20

9. Birthplace.....

Marion, Somerset, Md.

(Town, county, and state)

10. Usual occupation.....

House wife

11. Industry or business.....

12. Name.....

Estate Curtis

13. Birthplace.....

Eastville Va.

14. Maiden name.....

Irene Handy

15. Birthplace.....

Marion, Md.

16. Informant.....

A. H. Whittington

Address.....

Marion, Md.

17. Burial.....

Date thereof.....

(Burial, cremation, or removal. Which?)..... (month) (day) (year)

Sept 27 1945

Cemetery or crematory.....

Family Cemetery

Location.....

Marion, Som. Co. Md.

18. Funeral director.....

G. W. Tilghman

Address.....

Marion, Som. Co. Md.

19. 9/26 1945 Aurelia B. Lawton

(Date rec'd by registrar)..... Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Somerset

City or town..... Marion Sta.

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Sept 23 1945 at 5<sup>30</sup> P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....

Sept 14 1943 to Sept 23 1945

and that I last saw her alive on Sept 23 1945

Immediate cause of death.....

Hemorrhage from cancer of the breast

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

S. Alexander Rose M. D. or other

Address.....

Christfield

Date signed 9-24-45

RECEIVED  
OCT 2 1945  
BUREAU V.S.